



APPLICATION FOR RESIDENTIAL TREATMENT

Instructions: The following form is required to begin the application process to Stonehenge. The form should be printed and completed by hand, then faxed or mailed to Stonehenge (info below). If you already have an Assessment appointment booked, you can bring the completed form on that day, instead of sending it ahead of time. To schedule an Assessment appointment, please contact the Stonehenge Reception office at (519) 837-1470, Ext. 0

Mailing Address: Stonehenge Therapeutic Community, c/o Admissions, 60 Westwood Road, Guelph, Ontario N1H 7X3

Fax Number: Completed applications can be faxed to (519) 837-3232. Please mark with 'Attention: Admissions'.

Admission Coordinator Phone Extensions: Women's Residential Program – 226; Men's Residential Program – 227.

Website: Detailed information on our programs and the assessment process can be found at www.stonehenge.com.

OFFICE USE ONLY

Referred On:				
Status:	<input type="checkbox"/> Health	<input type="checkbox"/> Provincial Corrections	<input type="checkbox"/> Federal Corrections	<input type="checkbox"/> Fee-for-Service

START HERE

Date this form was completed:	
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Personal Information

First Name:		Last Name:	
Full name at birth (if different than above):			
If you use an alternate name, please include it:			
Date of Birth:		Gender:	
Do you have a valid Ontario Health Card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Card Number:	
Home Address:		City:	
Postal Code:		No Fixed Address?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current Location (if different than above):			
Phone Number:		Okay to leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Emergency Contact:		Relationship:	
Emergency Contact Phone #:		Okay to leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Language you prefer to receive service in?			
Ethnicity (e.g. Canadian, First Nations, Irish, etc):			

Referral Information

Please specify the referring agency(ies):	
Contact Name at referring agency(ies):	
Please check the boxes that explain who referred you to Stonehenge:	

APPLICATION FOR RESIDENTIAL TREATMENT

<input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Initial Assessment Treatment Planning <input type="checkbox"/> Withdrawal Management Centre <input type="checkbox"/> Community Withdrawal Management <input type="checkbox"/> Residential Addictions <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Outpatient Addictions	<input type="checkbox"/> Day/Evening Addictions <input type="checkbox"/> Psychiatric Services <input type="checkbox"/> Psychiatrist/Psychologist <input type="checkbox"/> Medical Services <input type="checkbox"/> Community Health Centre <input type="checkbox"/> Physician/Private Practice <input type="checkbox"/> Public Health Unit Nurse <input type="checkbox"/> Community Mental Health	<input type="checkbox"/> Correctional Facility <input type="checkbox"/> Non-Addictions Residential <input type="checkbox"/> Self-Help Group <input type="checkbox"/> EAP/Employer <input type="checkbox"/> Police <input type="checkbox"/> Other Legal <input type="checkbox"/> DART/Connex website <input type="checkbox"/> Other
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Employment Status:	<input type="checkbox"/> (Self) Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Unemployed (looking for work) <input type="checkbox"/> Student/Re-training	<input type="checkbox"/> Disability <input type="checkbox"/> Not in Labour Force (eg. homemaker) <input type="checkbox"/> Retired
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Education: (highest level achieved)	<input type="checkbox"/> No formal schooling <input type="checkbox"/> Some Primary School <input type="checkbox"/> Completed Primary School <input type="checkbox"/> Some Secondary or High School <input type="checkbox"/> Completed Secondary or High School	<input type="checkbox"/> Some College/CEGEP/Nursing <input type="checkbox"/> Completed College/CEGEP/Nursing <input type="checkbox"/> Some University (not complete) <input type="checkbox"/> Completed University Degree/Masters/PhD
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Income Source:	<input type="checkbox"/> Disability Insurance <input type="checkbox"/> Employment <input type="checkbox"/> Employment Insurance (E.I.) <input type="checkbox"/> Family Support <input type="checkbox"/> None	<input type="checkbox"/> Ontario Disability (ODSP) <input type="checkbox"/> Ontario Works (OW) <input type="checkbox"/> Other <input type="checkbox"/> Other Insurance (excluding E.I.) <input type="checkbox"/> Retirement Income
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Previous Substance Treatment

Have you had previous substance treatment?	<input type="checkbox"/> Yes (if yes, complete chart below)	<input type="checkbox"/> No	
Treatment Facility / Location	Type of Treatment	Date Attended (mm/yyyy)	Program Length

Have you had previous treatment at Stonehenge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; when: _____
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Identified Family

Please identify your current relationship status:	<input type="checkbox"/> Married <input type="checkbox"/> Partnered/Common Law <input type="checkbox"/> Single (never married)	<input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced/Separated
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Birth Place:	_____
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APPLICATION FOR RESIDENTIAL TREATMENT

Please identify your immediate family members below:

Family Member Name	Relationship	Age	Do you have contact with them?	Are they supportive of treatment?	Do they abuse drugs or alcohol?

If you have children, please complete the information below:

Name of Child	Age	Who do they live with?

Are you currently involved with any of the following services (check more than one, if necessary):

Family & Children’s Services
 First Nations Family Services
 Other: _____

Legal Status

FPS#: _____ OTIS#: _____

Are you applying to Stonehenge for Parole? Yes No

If yes, please indicate type: Provincial Federal - Day Parole Federal - Full Parole

What is your Parole Eligibility date? (day/month/year) _____

If incarcerated, what institution are you currently at? _____

Probation / Parole Officer: _____ Phone: _____

Lawyer: _____ Phone: _____

Legal Status:

No Problems On Parole
 Awaiting Trial or Sentencing Incarcerated
 On Probation Other: _____

Treatment Mandated/Required:

None/No Conditions Condition of Employment
 Choice of Treatment or Incarceration Condition of Family
 Condition of Probation/Parole Other: _____
 Family & Children’s Services Requirement

Do you currently have Young Offender status? Yes No

Do you have any charges, fines or warrants outstanding or pending? Yes No

APPLICATION FOR RESIDENTIAL TREATMENT

If yes, please explain:				
Please list any upcoming court dates:				
Are you currently participating in a Drug Treatment Court program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please provide your Drug Treatment Court worker's name:				
Contact Phone #:		Permission to contact?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list all prior Convictions	Year	Sentence	Juvenile	Adult
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
Physical Health Status				
Family Doctor Name (if applicable):		Doctor's Phone Number:		
Please check any health issues that apply to you:				
<input type="checkbox"/> Visual Impairment		<input type="checkbox"/> Pregnant		
<input type="checkbox"/> Hearing Impairment		<input type="checkbox"/> Communicable Diseases (eg. Hepatitis, HIV)		
<input type="checkbox"/> Mobility Concerns		<input type="checkbox"/> Acquired Brain Injury		
Please describe your physical health concerns:				
Please list any allergies you have:				
Please indicate the number of <u>overnight hospitalizations</u> in the last 12 months for <u>physical problems</u> :				
Please indicate the number of <u>Emergency Department visits</u> in the last 12 months for <u>any issue</u> :				
Reason for most recent hospitalization?				
Have you ever injected drugs for non-medical use?		<input type="checkbox"/> Never injected <input type="checkbox"/> Injected within the past year <input type="checkbox"/> Injected over a year ago		
Have you been diagnosed with a developmental or learning disability?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe:				
Mental Health Status				
Have you been <u>diagnosed</u> with a mental health problem by a qualified mental health professional...				
...within the last 12 months?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICATION FOR RESIDENTIAL TREATMENT

...within your lifetime?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:			
Have you been <u>hospitalized</u> for a mental health concern within the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been <u>hospitalized</u> for a mental health concern within your lifetime?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you received <u>treatment</u> for a mental health, emotional, behavioural or psychological concern from a professional...			
...currently?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
...within the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
...within your lifetime?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of service provider:			
Contact info for service provider:			
Are you prescribed medication for mental health concerns...			
...currently?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
...within the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
...within your lifetime?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you engage in self-harm behaviours (eg. cutting)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?	
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	
Have you ever overdosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	
Opioid Substitution			
Are you currently participating in an opioid substitution program?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please indicate which one:		<input type="checkbox"/> Methadone	<input type="checkbox"/> Suboxone
If yes, who is your prescriber?			
What is your current dosage?			
Medications			
Please indicate your current medication(s):		Please indicate your current dosage(s):	
1			
2			
3			
4			
5			
Current Substance Use			
What are your current drugs of choice? Please list in order of severity.		Please indicate below how often you used in the last 30 days for each substance.	

APPLICATION FOR RESIDENTIAL TREATMENT

1		<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly	<input type="checkbox"/> 3-6 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> Binge
2		<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly	<input type="checkbox"/> 3-6 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> Binge
3		<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly	<input type="checkbox"/> 3-6 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> Binge
4		<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly	<input type="checkbox"/> 3-6 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> Binge
5		<input type="checkbox"/> Did not use <input type="checkbox"/> 1-3 times monthly <input type="checkbox"/> 1-2 times weekly	<input type="checkbox"/> 3-6 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> Binge

Please indicate any substances used in the past **12 months** (select all that apply):

Substance	Date Used	Method of Use	
<input type="checkbox"/> Alcohol		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Amphetamines & other stimulants		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Barbiturates		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Benzodiazepines		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Cannabis		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Cocaine		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Crack		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Ecstasy/MDMA		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Glue/Inhalants		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed
<input type="checkbox"/> Hallucinogens		<input type="checkbox"/> Smoked <input type="checkbox"/> Snorted	<input type="checkbox"/> Injected <input type="checkbox"/> Swallowed

APPLICATION FOR RESIDENTIAL TREATMENT

<input type="checkbox"/> Heroin/Opium		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Methamphetamines (eg. crystal meth)		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Other psycho-active substances		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Over-the-counter Codeine		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Prescription Opioids		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Steroids		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Tobacco		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
<input type="checkbox"/> Other (please specify)		<input type="checkbox"/> Smoked	<input type="checkbox"/> Injected
		<input type="checkbox"/> Snorted	<input type="checkbox"/> Swallowed
How old were you when you first tried any drug or alcohol?			
How old were you when you first tried your current drug of choice?			
Gambling			
Have you ever had gambling identified as a problem?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you be interested in treatment for gambling?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please use the check boxes below to indicate any gambling activities engaged in the past 12 months :			
<input type="checkbox"/>	Bingo	<input type="checkbox"/>	Lottery tickets
<input type="checkbox"/>	Slot machines	<input type="checkbox"/>	Instant win or scratch tickets
<input type="checkbox"/>	Gaming machines (other than slots)	<input type="checkbox"/>	Internet gambling
<input type="checkbox"/>	Casino card or table games	<input type="checkbox"/>	Gambling with stock market or real estate
<input type="checkbox"/>	Non-casino card or table games	<input type="checkbox"/>	Betting on games of skill
<input type="checkbox"/>	Horse races	<input type="checkbox"/>	Betting on outcome of events
<input type="checkbox"/>	Sports betting	<input type="checkbox"/>	Other (please specify):

Thank you for completing the Stonehenge Application Form



APPLICATION FOR RESIDENTIAL TREATMENT

For Office Use Only:	
Has the assessment been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
On what date was the assessment completed?	
If no assessment was completed, please indicate why:	
Admissions Staff Name:	
Admissions Staff Signature:	